

Assembly Bill No. 2889

Passed the Assembly August 31, 2006

Chief Clerk of the Assembly

Passed the Senate August 28, 2006

Secretary of the Senate

This bill was received by the Governor this _____ day
of _____, 2006, at _____ o'clock ____M.

Private Secretary of the Governor

CHAPTER _____

An act to add Section 1389.5 to the Health and Safety Code, and to add Section 10119.1 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2889, Frommer. Health care coverage: individual market.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (the Knox-Keene Act), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Under existing law, a health care service plan and a health insurer are required to include specified coverage provisions in their plan contracts and policies.

This bill would require a health care service plan and a health insurer to permit, at least once each year, an individual who has been covered for at least 18 months under an individual plan contract issued by the health care service plan or an individual health benefit plan issued by the insurer to transfer without medical underwriting, as defined, to another individual plan contract or individual health benefit plan offered by the health care service plan or insurer having equal or lesser benefits, as specified. The bill would require a plan and an insurer to rank its products for these purposes and post the ranking on its Internet Web site or make the ranking available upon request. The bill would also require a plan and an insurer to notify its enrollees or insureds of their transfer rights under these provisions. The bill would specify that these requirements do not apply with respect to a federally eligible defined individual enrolled in certain health care coverage, an individual offered conversion coverage, as specified, or an individual enrolled in certain public health care programs.

Because the bill would specify additional requirements under the Knox-Keene Act, the willful violation of which would be

punishable as a crime, it would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. Section 1389.5 is added to the Health and Safety Code, to read:

1389.5. (a) This section shall apply to a health care service plan that provides coverage under an individual plan contract that is issued, amended, delivered, or renewed on or after January 1, 2007.

(b) At least once each year, the health care service plan shall permit an individual who has been covered for at least 18 months under an individual plan contract to transfer, without medical underwriting, to any other individual plan contract offered by that same health care service plan that provides equal or lesser benefits, as determined by the plan.

“Without medical underwriting” means that the health care service plan shall not decline to offer coverage to, or deny enrollment of, the individual or impose any preexisting condition exclusion on the individual who transfers to another individual plan contract pursuant to this section.

(c) The plan shall establish, for the purposes of subdivision (b), a ranking of the individual plan contracts it offers to individual purchasers and post the ranking on its Internet Web site or make the ranking available upon request. The plan shall update the ranking whenever a new benefit design for individual purchasers is approved.

(d) The plan shall notify in writing all enrollees of the right to transfer to another individual plan contract pursuant to this section, at a minimum, when the plan changes the enrollee’s premium rate. Posting this information on the plan’s Internet Web site shall not constitute notice for purposes of this subdivision. The notice shall adequately inform enrollees of the

transfer rights provided under this section, including information on the process to obtain details about the individual plan contracts available to that enrollee and advising that the enrollee may be unable to return to his or her current individual plan contract if the enrollee transfers to another individual plan contract.

(e) The requirements of this section shall not apply to the following:

(1) A federally eligible defined individual, as defined in subdivision (c) of Section 1399.801, who is enrolled in an individual health benefit plan contract offered pursuant to Section 1366.35.

(2) An individual offered conversion coverage pursuant to Section 1373.6.

(3) Individual coverage under a specialized health care service plan contract.

(4) An individual enrolled in the Medi-Cal program pursuant to Chapter 7 (commencing with Section 14000) of Division 9 of Part 3 of the Welfare and Institutions Code.

(5) An individual enrolled in the Access for Infants and Mothers Program pursuant to Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code.

(6) An individual enrolled in the Healthy Families Program pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code.

(f) It is the intent of the Legislature that individuals shall have more choice in their health coverage when health care service plans guarantee the right of an individual to transfer to another product based on the plan's own ranking system. The Legislature does not intend for the department to review or verify the plan's ranking for actuarial or other purposes.

SEC. 2. Section 10119.1 is added to the Insurance Code, to read:

10119.1. (a) This section shall apply to a health insurer that covers hospital, medical, or surgical expenses under an individual health benefit plan, as defined in subdivision (a) of Section 10198.6, that is issued, amended, renewed, or delivered on or after January 1, 2007.

(b) At least once each year, a health insurer shall permit an individual who has been covered for at least 18 months under an

individual health benefit plan to transfer, without medical underwriting, to any other individual health benefit plan offered by that same health insurer that provides equal or lesser benefits as determined by the insurer.

“Without medical underwriting” means that the health insurer shall not decline to offer coverage to, or deny enrollment of, the individual or impose any preexisting condition exclusion on the individual who transfers to another individual health benefit plan pursuant to this section.

(c) The insurer shall establish, for the purposes of subdivision (b), a ranking of the individual health benefit plans it offers to individual purchasers and post the ranking on its Internet Web site or make the ranking available upon request. The insurer shall update the ranking whenever a new benefit design for individual purchasers is approved.

(d) The insurer shall notify in writing all insureds of the right to transfer to another individual health benefit plan pursuant to this section, at a minimum, when the insurer changes the insured’s premium rate. Posting this information on the insurer’s Internet Web site shall not constitute notice for purposes of this subdivision. The notice shall adequately inform insureds of the transfer rights provided under this section including information on the process to obtain details about the individual health benefit plans available to that insured and advising that the insured may be unable to return to his or her current individual health benefit plan if the insured transfers to another individual health benefit plan.

(e) The requirements of this section shall not apply to the following:

(1) A federally eligible defined individual, as defined in subdivision (e) of Section 10900, who purchases individual coverage pursuant to Section 10785.

(2) An individual offered conversion coverage pursuant to Sections 12672 and 12682.1.

(3) An individual enrolled in the Medi-Cal program pursuant to Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code.

(4) An individual enrolled in the Access for Infants and Mothers Program, pursuant to Part 6.3 (commencing with Section 12695).

(5) An individual enrolled in the Healthy Families Program pursuant to Part 6.2 (commencing with Section 12693).

(f) It is the intent of the Legislature that individuals shall have more choice in their health care coverage when health insurers guarantee the right of an individual to transfer to another product based on the insurer's own ranking system. The Legislature does not intend for the department to review or verify the insurer's ranking for actuarial or other purposes.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Approved _____, 2006

Governor